

AUTHORIZATION FOR MEDICAL TREATMENT

This agreement, dated _____, 2010 is made between The Country Trailblazers Inc., Stillwater Equestrian Chapter, ("Country Trailblazers") and

_____.

Country Trailblazers is located at (Street Address of Registered Agent for Service of Process), Stillwater, New York, 12170.

I authorize Country Trailblazers to perform on-site first aid for minor injuries.

Country Trailblazers is authorized to obtain any and all medical treatment Country Trailblazers deems reasonably necessary for my care. Country Trailblazers shall incur no financial liability for medical treatment obtained pursuant to this authorization.

I agree to assume all costs related to such treatment.

I authorize my insurance company to pay benefits for costs of such treatment.

I authorize disclosure of medical information to my insurance company.

Social Security Number:

Health Insurance Plan/Identification/Policy Number:

Health Insurance Carrier:

Primary Healthcare Provider:

Telephone Number:

Preferred Hospital:

Date of last tetanus immunization:

Medical conditions (i.e., allergies, asthma, epilepsy, diabetes, etc.):

Medications currently being taken and for what conditions:

Telephone Number:

Signature

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